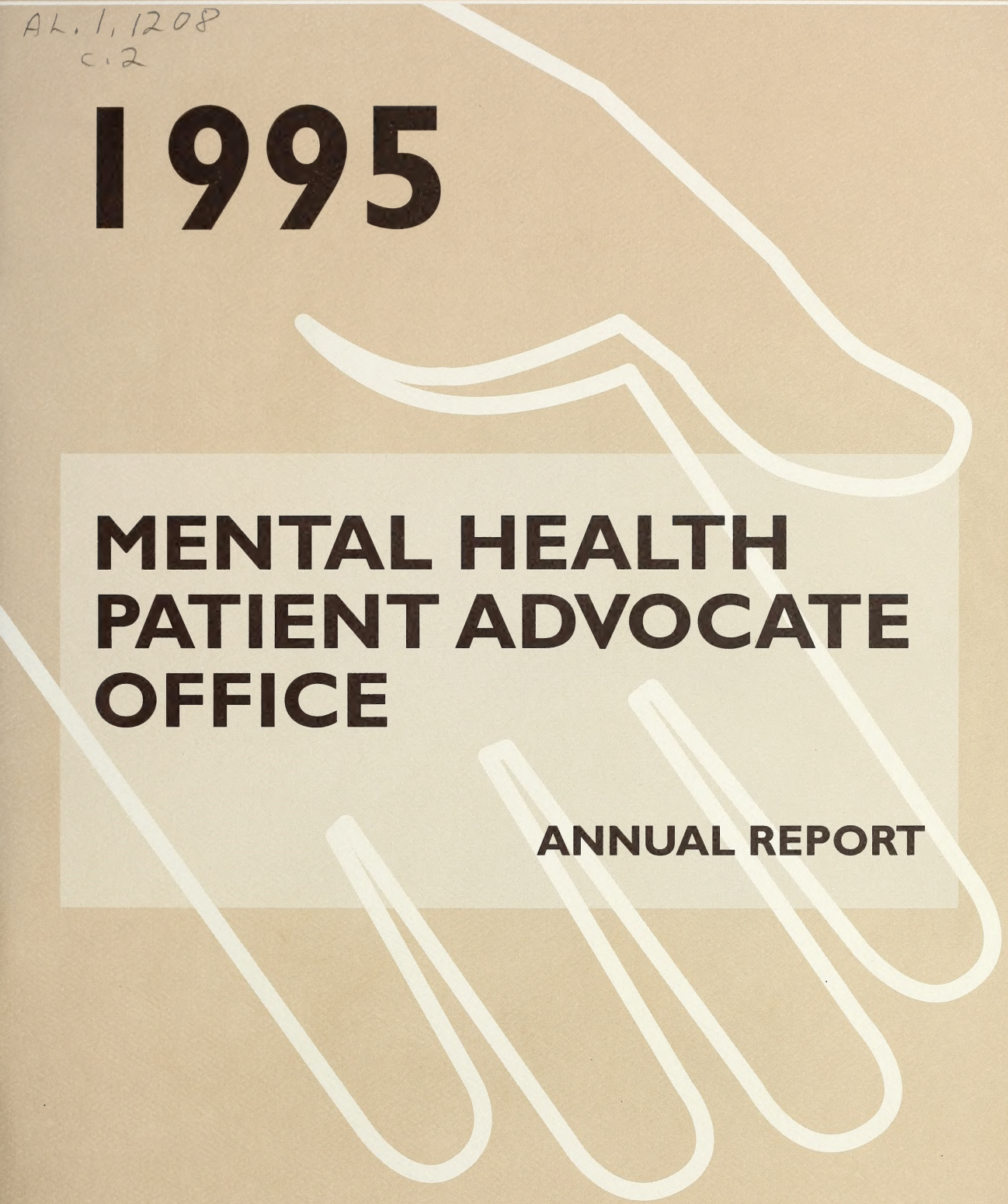
1995

MENTAL HEALTH PATIENT ADVOCATE OFFICE

ANNUAL REPORT



Alberta
HEALTH

ALBERTA
HEALTH

Office of the Minister

Minister Responsible for the Wild Rose Foundation
Minister Responsible for AADAC

April, 1996

The Honourable Stanley S. Schumacher Q.C.
Office of the Speaker
Legislative Assembly of Alberta
Room 325
Legislature Building
Edmonton, Alberta
T5K 2B6

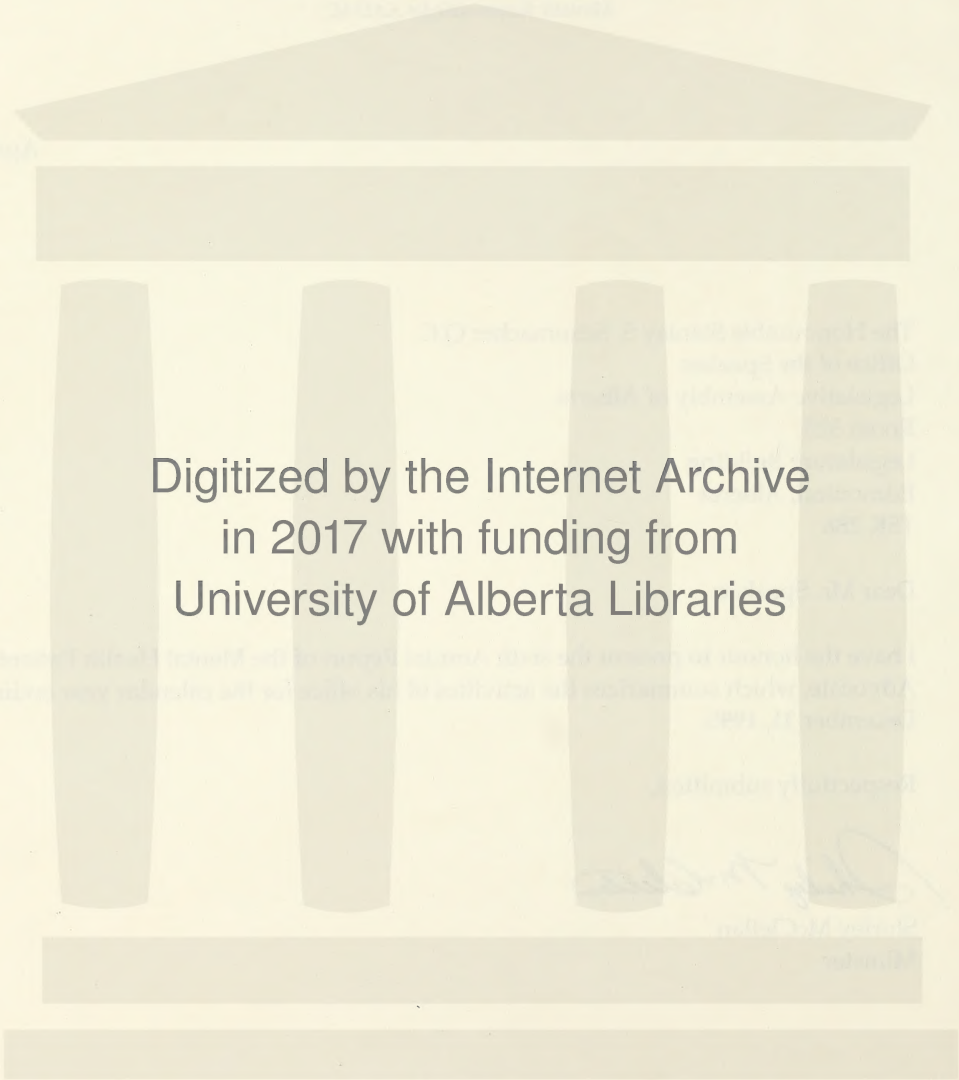
Dear Mr. Speaker:

I have the honour to present the sixth Annual Report of the Mental Health Patient Advocate, which summarizes the activities of his office for the calendar year ending December 31, 1995.

Respectfully submitted,

Shirley McClellan
Minister

127 Legislature Building, Edmonton, Alberta, Canada T5K 2B6 Telephone 403/427-3665 Fax 403/429-5954



Alberta
HEALTH
Mental Health Patient
Advocate Office

12th Floor, Centre West Bldg., 10035 – 108 Street, Edmonton, Alberta, Canada T5J 3E1 403/422-1812

April, 1996

The Honourable Shirley McClellan
Minister of Health
Room 127
Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Madam Minister:

I am pleased to present you with the sixth Annual Report of the Mental Health Patient Advocate, summarizing activities of the Advocate's Office for the calendar year ending December 31, 1995.

This report is submitted in accordance with the provisions of **s.47(1)** of the **Mental Health Act** for your presentation to the Legislative Assembly.

Respectfully submitted,

M. W. Hislop, PhD, R. Psych., CHE
Mental Health Patient Advocate

Contents

Preliminary Comments

Compared with the continuing changes that have characterized the progress of health care reform throughout the province, the Mental Health Patient Advocate Office experienced a relatively uneventful year in 1995. Caseloads were up slightly over 1994, but appear to remain within the normal range of year-to-year variation. Resource service requests increased more significantly, however, as did the total numbers of issues handled by the office. Despite the Advocate's small staff, these increases and the additional numbers of contacts required to resolve issues this year did not diminish the office's ability to respond with immediacy to most client calls.

Ongoing health care restructuring renders it difficult to discern clear trends, but subjectively, increasing numbers of concerns appear to focus on perceived gaps or deficiencies in health services delivery — particularly in the community. Some complaints have focused on inordinate delays and repeated transfers between facilities because of bed unavailability on admission. These latter occurrences may be related to recently-voiced concerns that psychiatric patients are receiving decreasingly responsive and increasingly inadequate attention in hospital emergency units because of concomitant triage difficulties or other patients with more pressing problems. Psychiatric nursing staff have repeatedly lamented as well that they are unable to interact sufficiently with patients in their charge due to competing commitments and demands. Certainly, progressive restructuring continues to impact staff morale in many health care settings, but these inevitable transition pains should hopefully abate somewhat as current uncertainties become clarified.

Many of these presenting problems fall beyond the jurisdiction of our office and are thus referred for response to appropriate facility officials, Regional Health Authorities or the Provincial Mental Health Board. Ultimate responsibility for service shortfalls, however, has often appeared diffuse, with referred callers reporting they have been informed that such matters simply constitute "site problems" which can not be controlled or addressed by a central health authority.

Other difficult to quantify observations include frequent reports of increased acuity on the part of patients being served by both hospital and community care components of the service system. In more stable times, increased acuity levels might be reflected by hospital admissions, length of stay data, numbers of patients requiring formal certification, or the frequency of hearings held by Mental Health Review Panels. Some of these indices are currently unreliable, however, since they are confounded by other conflicting variables in the changing health care scenario. Admission increases, for example, are negated by pressures to reduce inpatient services in favour of enhanced community care. Similarly, longer lengths of stay can be confounded by fiscal and organizational initiatives to discharge patients back into the community earlier despite augmented acuity levels.

Notwithstanding the vagaries that intrinsically arise from extensive systemic reform, a few observations do appear to support the subjective but consistently reported increases in patient acuity. One of these is the continuing and progressive increases in the numbers of patients requiring formal certification. My 1994 report cited both absolute and proportionate increases in psychiatric patients meeting the prescribed criteria for certification and involuntary detention. At that time, it was observed that the numbers of formal patients had increased about 100 over the preceding year. This trend has apparently continued through 1995, when an estimated 2,100 psychiatric patients required committal under the **Mental Health Act**. Once again, this increase represents approximately 100 more patients requiring certification than in the previous year. Since both hospital beds and concomitant admission rates declined during this same period, the proportion of inpatients requiring formal certification has increased more dramatically than the absolute numbers, and now stands at about 22 percent of all psychiatric admissions. Just a few years ago, by contrast, my 1990 Annual Report documented less than 17 percent of psychiatric admissions to require committal and compulsory detention in designated mental health facilities.

While these collective data are not particularly cogent, they are consistent with frequently voiced concerns expressed by health care providers that acuity levels of patients in our psychiatric service system are increasing. Other indices may also be suggestive of this trend. While the proportion of formal patients rose only 5 percent, detention appeals adjudicated by Provincial Mental Health Review Panels under **ss. 38** and **39** of the **Mental Health Act** increased over 10 percent, and **s.29** Treatment Orders granted by these tribunals rose 16 percent during the last year for which information is available. Other Review Panel data are equivocal in supporting increased acuity levels, however, in that they fail to reveal concomitant changes in the numbers of **s.27** competency hearings held during the same period or increases in the proportions of unsuccessful appeals under the **Act**.

There were no changes during 1995 to the listing of hospitals designated under the **Mental Health Act** as having authority to admit and detain formal patients. Once again, reliable admissions data for these facilities have proved frustratingly difficult to come by through Alberta Health sources. Nonetheless, a reasonably clear and expected trend was witnessed in 1993-94 by a decrease of about 500 in overall psychiatric admissions to designated facilities. This trend also appears to have continued through 1995, the data for which reflect a further drop of over 350. Total psychiatric admissions to designated mental health facilities thus declined to approximately 9,750 this year — despite the aforementioned increases in numbers of inpatients requiring formal certification and continued compulsory detention.

Notwithstanding these turbulent times, our inquiries and investigations into patient concerns have continued to be met with willing and courteous cooperation from most facilities. Indeed, the Patient Advocate Office is often asked to serve as a resource for hospital staff with respect to patient care problems, rights related issues or difficult situations involving perceived conflicts of interest. The office continues to promote responsible advocacy in responding to requests for assistance. While attempting to strike the appropriate and often delicate balances required to resolve problems presented by or on behalf of formal patients, the office also encourages the utilization of existing internal mechanisms set up by social agencies and institutional facilities for addressing individual concerns, if these are available. In addition, the office maintains open communications and reciprocal referrals with other external authorities offering assistance in the redress of public concerns. Interaction has increased this year with the Regional Health Authorities and the Provincial Mental Health Board, as have collaborative efforts with the offices of the Public Guardian and Public Trustee.

The monitoring of Public Inquiries for patients in designated psychiatric facilities has continued upon routine notification of these hearings from authorities in Alberta Justice. Two fatality inquiries were personally attended by the Patient Advocate during 1995. Active involvement in one of these cases occurred prior to the court proceedings, and upon request the official findings of a third unattended inquiry were communicated to the Patient Advocate by the Chief Medical Examiner. Finally, the office continues to review pending and newly enacted legislation which can potentially impact psychiatric patients and services (eg., **Freedom of Information and Protection of Privacy Act; Protection for Persons in Care Act**), and the Patient Advocate attended both general and in-depth orientation sessions on the former recently proclaimed statute. The Advocate also participated during the year in formal training sessions on the conducting and documenting of quasi-judicial hearings; these locally held programs were offered by the Canadian Institute for the Administration of Justice, which is affiliated with the Faculty of Law at the University of Montreal.

It seems that Alberta's leadership in developing a legislated psychiatric patient advocacy service is finally being emulated by other provincial jurisdictions. While buffeted by extensive amendments to that province's recently proclaimed protective legislation, Ontario's Psychiatric Patient Advocacy Office nonetheless continues to flourish after over twelve years of service. Recent reports confirm that British Columbia continues to pursue the development of a dedicated psychiatric patient advocacy service as well, but it is uncertain whether the office will evolve as a creature of legislation or emulate Ontario's administrative model. The Province of New Brunswick, however, has directly followed Alberta's lead in developing a legislated psychiatric patient advocacy office reporting to the Minister of Health; this latter statutorily based service has been active since 1994.

Dialogues with these parallel offices in other jurisdictions reveal clear commonalities in operating philosophy, notwithstanding inherent differences deriving from their respective administrative and legislated underpinnings. None fastidiously focus on lobbying for their constituents in the manner that characterizes most consumer advocacy endeavours. While fostering and supporting systemic change in services to vulnerable persons, none strive to serve as convenient conveyances for implementing the concerns of vested interest groups. Nor do these 'official' advocacy offices attempt to be intrusive in treatment matters, but focus rather on rights related issues and improving the context in which care is given; in this, their mandates echo the provisions of prevailing American Federal legislation.[1] All attempt to capture an objective sense of fairness in adjudicating issues involving decisions which are seen to have failed in striking an appropriate balance between apparently conflicting rights of individuals, agencies and society at large.

A cardinal *raison d'etre* underlying the inception of these dedicated psychiatric advocacy services is growing recognition that the loci for service delivery are rapidly moving from centralized sites such as provincial mental health facilities and extending instead into a range of regionalized service centres in the community. Wherever located, there is also increasing acknowledgement of the highly specialized needs and unique 'legal space' of involuntary psychiatric patients, who represent the sole segment of our society which has historically been deprived of fundamental freedoms without the due process accorded other citizens — even those in our criminal justice systems. In short, it seems that independent, appropriately authorized advocacy and monitoring mechanisms are increasingly seen as critical to the public confidence that vulnerable patients' problems or complaints will be documented and dealt with in an informed, impartial and timely fashion.

[1] Protection and Advocacy for Mentally Ill Individuals Act, 1986, U.S.C. (amended 1988, 1991).

The Mental Health Patient Advocate Office

The **Alberta Mental Health Act** provides for the appointment of a Mental Health Patient Advocate to assist patients in designated psychiatric facilities to understand and exercise their rights. The Advocate's Office also has authority to investigate concerns or complaints relating to patients who are certified and involuntarily detained under the **Act**. Systemic and rights related information pertaining to psychiatric patients and services is offered as well to the general public. The Patient Advocate reports to the Minister of Health, who is required to lay copies of the Advocate's annual reports before the Legislative Assembly at times prescribed in the **Act**. The Patient Advocate Office consists of the Advocate, an Assistant Patient Advocate and a Receptionist/Secretarial support position. This small staff complement, coupled with a province-wide mandate, dictate that considerable office activity transpire via telephone, facsimile and correspondence. Regular visits to designated psychiatric facilities around the province do occur on a routine basis, however, both proactively and in response to individual or collective complaints.

Inquiries about any individual who is or has been a formal patient may be directed to the Patient Advocate Office. Formal patients are persons who are involuntarily detained in designated psychiatric facilities under two Admission or two Renewal Certificates as prescribed in the **Mental Health Act**. Thirteen hospitals throughout the province are currently designated as psychiatric facilities able to admit and detain formal patients; a listing of these is provided in the Appendices. If it is uncertain whether an individual who is the subject of concern has been formally certified under the **Act**, the Patient Advocate Office can be contacted to determine the legal status of the patient. Telephone inquiries may be directed to the downtown Edmonton office at **422–1812**; calls from locations outside the greater Edmonton area may be placed free of long-distance charges through local Alberta Government RITE operators. Written complaints should contain as much detailed information as possible, be marked 'Confidential', and mailed directly to:

Office of the Mental Health Patient Advocate
12th Floor, Centre West Building
10035 – 108 Street
Edmonton AB T5J 3E1.

There are no limits on the kinds or numbers of complaints that may be made to the Patient Advocate Office, so as long as issues requiring investigation relate to a period during which the person who is the subject of concern was certified under the **Mental Health Act**. When the Patient Advocate Office receives an inquiry or complaint, information will be provided concerning:

- the detailed rights of formal patients under the **Mental Health Act**;
- how formal patients may obtain legal assistance;
- how applications are made to the Review Panel;
- how appeals may be commenced to the Court of Queen's Bench.

Responses to inquiries not requiring formal investigative procedures are provided on a same-day basis. The Patient Advocate Office initially reviews any issues presented in order to ensure that it has authority to pursue them. If the office does not have jurisdiction it may make general inquiries relating to the matter, but will do so only by way of informal assistance; no formal investigations can be authorized or undertaken. Non-jurisdictional issues are referred to an appropriate office or agency having authority to address the problem, if such sources are available. In this regard, the Patient Advocate maintains open and reciprocal communications with other authorities offering mechanisms for redressing public concerns (eg., the Provincial Ombudsman, Police Commissions, the Children's Advocate, Human Rights Commission, etc.).

If issues presented are jurisdictional, a decision is made as to whether the concerns raised require a formal investigation. Whenever possible the office attempts to resolve matters informally, and 'official' procedures are not normally needed to address most concerns presented by or on behalf of formal patients. Where allegations are of a sensitive nature or serious accusations are made against specifically named individuals, however, formal investigative protocols usually become mandatory. In these instances, the Patient Advocate is required to provide written notification to any patient who is the subject of an investigation, the Boards of all facilities involved, and any other persons named in the complaints. An investigator is assigned to interview principal parties and review relevant clinical charts, administrative records and other documents relating to the issues raised. All inquiries necessary to complete the investigation are undertaken, and the office can engage the services of lawyers, psychiatrists or other specialists to assist in this process, if required. The Patient Advocate Office does not need a complaint in order to initiate an inquiry or investigation into facility procedures for admitting persons detained under the **Mental Health Act**, or for providing information as required by the **Act** to formal patients, guardians, nearest relatives or patient designates.

When an inquiry or investigation is completed, the Patient Advocate Office advises the patient and other principal parties as appropriate regarding the disposition of problems presented for resolution. In the case of formal investigations, these notifications are provided in writing, and all facilities in which the patient has been detained receive a report which includes case specific and/or systemic recommendations relating to the issues investigated. All inquiries are conducted in strict confidence, and the Patient Advocate Office will not disclose any information obtained during an investigation except as required by law or by the performance of its duties under the **Mental Health Act** and **Patient Advocate Regulation**.

MISSION STATEMENT

To serve as a resource for psychiatric patients by:

- Assisting formal (certified) patients involuntarily detained in facilities designated under the Mental Health Act to understand and exercise their rights;
- Investigating and facilitating redress for concerns and complaints relating to formal patients;
- Assessing and recommending revision to facility procedures for:
  - Admitting persons detained under the Mental Health Act;
  - Informing formal patients of their rights;
  - Providing information as required by the Act to guardians, relatives or designates of formal patients;
- Advocating for amendments to mental health and other protective legislation as these relate to formal patients;
- Offering a consumer oriented source of information for persons with mental illness and others acting on their behalf;
- Supporting client perspectives in the development and implementation of mental health policies and procedures;
- Promoting public, professional and consumer awareness of rights related issues in mental health.

A. General

Statistical summaries for Patient Advocate Office activities during the 1995 calendar year are provided in **Table I**. These data comprise a combination of resource service and case file activities.

Table I

Resource Services	
Issues	669
Contacts	526

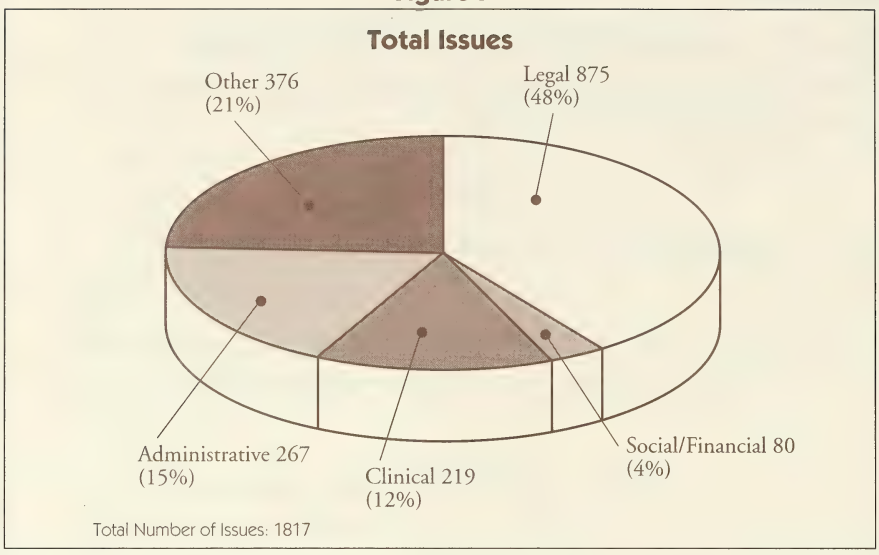
Case Files	
Issues	1,148
Contacts	1,609
New Files opened	237

Overall Activity

Total Issues	1,817
Total Contacts	2,135

The Patient Advocate Office engaged in a total of 2,135 personal, telephone or written contacts with Alberta citizens during 1995. These contacts reflect a 35 per cent increase over those documented for the previous year, and they involved the addressing of 1,817 independent issues. The latter issues are broken down by category in **Figure I**; these categories are approximate since many matters can be classified in more than one way, depending on the relative emphasis involved. The overall issues addressed during the year represent a 10 per cent increase over the total issues tallied for 1994. For six consecutive reporting periods the numbers of issues presented to the Patient Advocate Office for resolution have increased progressively each succeeding year. The issues addressed during 1995 covered a similarly wide range of topics as was witnessed in previous years; a few of these receive more detailed discussion in the subsequent 'Issues' section which follows. As in previous years, the preponderance of presenting problems continue to be of a legal nature, reflecting ongoing emphases on the involuntary apprehension, detention and treatment provisions of the **Mental Health Act**.

Figure I



B. Resource Services

Resource service contacts totalled 526 during 1995, an increase of 11 per cent over those recorded last year. Resource contacts comprise both office initiated and response related activities in which the office is used as an information source for persons seeking advice on individual problems or systemic matters relating to psychiatric services. Case files are not opened in these instances since callers are not concerned with specific patients detained in designated mental health facilities. Most of these resource service requests came from individual citizens; the remainder emanated from a diverse range of agencies including government departments, legal firms, professional associations, MLA offices, consumer organizations and health or social service providers across Alberta. A few came as well from concerned citizens, agencies or officials in other provincial jurisdictions. Many of these resource contacts were proactive. In addition to case related communications, all facilities designated under the **Mental Health Act** are routinely contacted on a periodic basis, either by telephone or via personal attendance by way of on-site visits. Only a few facilities in the province which serve relatively small numbers of formal psychiatric patients are not proactively visited on a fairly frequent and routine basis for the purposes of meeting with patients and staff. The number of individual issues or problems presented in the context of collective resource service requests received over the year was 669 — a figure almost identical to that documented for 1994.

C. Case Work

Two hundred thirty-seven new case files were opened during 1995, in the context of which 1,148 independent issues were presented for resolution. These figures represent a 10 per cent increase in new case files and a 15 per cent increment in case related issues over the previous year. Even larger increases were witnessed in the numbers of personal, written and telephone contacts required to resolve these collective case related concerns. The 1,609 case contacts recorded during the year denote a 46 per cent increase over those documented for 1994. While these figures are inflated somewhat by the persistent efforts of a few recidivist callers, they nonetheless result in a mean of almost seven contacts per file — significantly higher than the averages observed in previous years.

The following graphs and tables delineate various breakdowns of case related activity for the year; where required, these data are accompanied by appropriate definitions and interpretive comments. Unless otherwise noted, the proportions and breakdowns presented are comparable with previous years' findings.

Figure II provides a breakdown of initial case contacts, showing the numbers and proportions involving patients themselves, family members and agencies on their behalf, or other alternate sources (friends, neighbours, landlords, MLAs, other patients, concerned citizens, etc.). Almost 84 per cent of these initial case contacts consisted of telephone inquiries; the balance were predominantly personal contacts deriving from our routine site visits to designated psychiatric hospitals.

Figure II

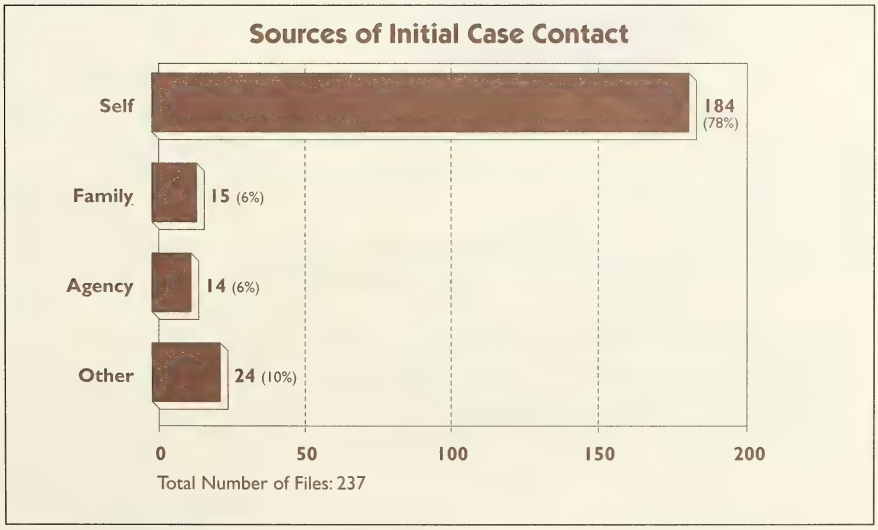


Figure III describes the categories of legal status for subjects of call in case activity during the year. The term 'subject of call' refers to patients for whom case files have been opened and not necessarily to the initial contact sources involved. The phrase 'other involuntary' denotes patients under compulsory detention in designated mental health facilities by way of Disposition Orders from the Courts or Forensic Boards of Review, Compulsory Care Orders under the **Dependent Adults Act**, or single Admission Certificates pursuant to the **Mental Health Act**. The concerns and complaints of these involuntary psychiatric patients in designated facilities continue to be non-jurisdictional for this office. The term 'other' simply represents a catch-all category for subjects of call not falling into any of the other classifications. It reflects persons recently or currently in hospital whose legal status was either irrelevant to the presenting problem or undetermined due to lack of information from the complainant. Two thirds of case file requests for assistance involved currently certified patients, a figure almost identical to that recorded last year. The remaining one third derived from voluntary patients, those involuntarily admitted on only one medical certificate, or patients detained under authorities other than the **Mental Health Act**.

Figure III

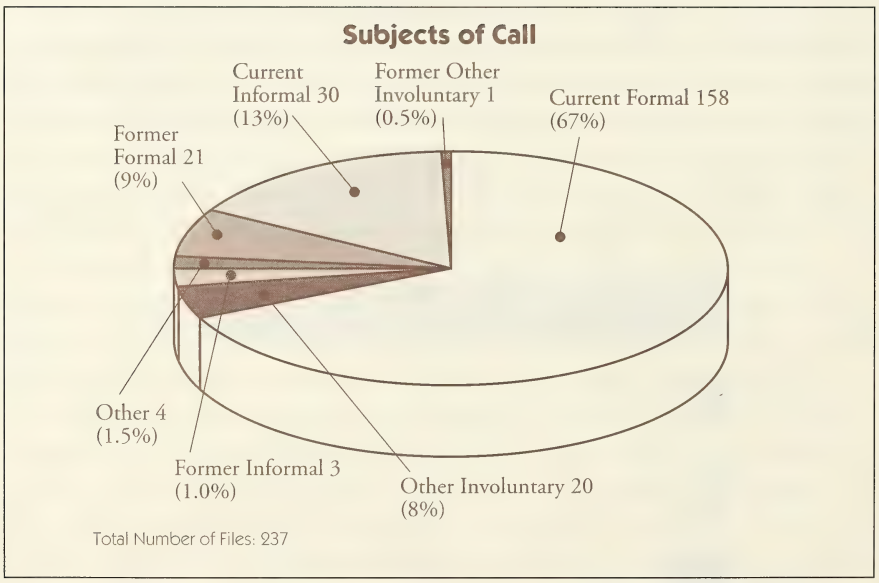


Table II speaks to the disposition of case related issues addressed during 1995, illustrating outcomes independently for jurisdictional and non-jurisdictional matters. Of the 1,148 independent issues presented to the office in the context of case file activities, 888 or 77 per cent were jurisdictional — a figure equivalent to that observed last year. Nearly three quarters (74 per cent) of all presenting problems were 'resolved', but as in previous reports this does not necessarily reflect complete consumer satisfaction in all instances. Rather, it denotes tangible actions and outcomes which capture all that might reasonably be accomplished by an advocacy service relative to the matters presented for assistance and/or resolution.

Table II
Issues — Disposition

Period January 1, 1995 — December 31, 1995

Disposition	Jurisdictional	Non-Jurisdictional	Total No.	%
R	797	52	849	74
U	3	2	5	0.5
D	23	11	34	3
D&R	44	185	229	20
NR/NA	14	6	20	1.5
NR/RNF	7	4	11	1
Total Issues	888	260	1148	100

Legend:

R — Resolved
(fully or partially; see previous note)

U — Unsubstantiated
(verification not obtained, or issue remains sufficiently undefined as to preclude pursuit)

D — Discontinued
(enquiries/investigation dropped by the office or complainant due to lack of ability/need to further pursue; this can include an inability to establish jurisdiction)

D&R — Declined and Referred
(pertains primarily to non-jurisdictional issues when information or informal assistance are inappropriate or insufficient to resolve the matter; for jurisdictional concerns, denotes either that the patient is capable of pursuing remedy via established mechanisms but has made no attempts to do so, or that ultimate resolution is beyond the scope of office authority)

NR/NA — Not Resolved
(remedy not available)

NR/RNF — Not Resolved
(recommendations not acted upon, or investigation/follow-up not yet completed)

D. Agency Contacts

The Patient Advocate Office deals with a wide range of individuals, offices and agencies each year. The following is a listing of most major sources other than individual complainants with which the office had direct contact during 1995.

Government Departments And Offices:

Alberta Alcohol and Drug Abuse Commission

Alberta Family and Social Services

- Appeal and Advisory Secretariat
- Assured Income Programs
- Children's Advocate
- Department of Child Welfare
- Legislative Planning
- Michener Centre: Red Deer
- Public Guardian
    - Provincial Office
    - Regional Offices
- Social Care Facilities Review Committee

Alberta Health

- Area Services
- Communications
- Corporate Services
- Deputy Minister
- Finance and Health Plan Administration
- Freedom of Information, Privacy and Protection
- Health Facilities Review Committee
- Human Resources Services
- Information Services
- Legislative and Contract Services
- Mental Health Services
    - Provincial Office
    - Review Panel Chairpersons
- Minister
- Population Health
- Practitioner Services
- Professional Services

Alberta Justice

- Civil Law Section
- Constitutional Law Section
- Crimes Compensation Board
- Family Court Services
- Medical Examiner
  - Calgary
  - Edmonton
- Public Trustee

Alberta Labour

- Human Rights Commission

Ethics Commissioner

MLA Offices:

- Jocelyn Burgener (Calgary-Currie)
- David Coutts (Pincher Creek-Macleod)
- Laurence Decore (Edmonton-Glengarry)
- Julius Yankowsky (Edmonton-Beverly-Belmont)

Premier's Council on Persons with Disabilities

Provincial Ombudsman

Other Government Departments And Offices:

British Columbia Ministry of Health

- Mental Health Division
- Senior Health Law Consultant

City of Edmonton: Community and Family Services

- Youth Employment Centre

Edmonton Public School Board

Employment and Immigration Canada

New Brunswick Ministry of Health

- Psychiatric Patient Advocate: Moncton

Ontario Ministry of Citizenship

- Office for Disability Issues
- Psychiatric Patient Advocate: Toronto

Provincial Courts

- Security Office

Provincial Ombudsman: British Columbia

Public Guardian: Toronto, Ontario

United States Consulate

Facilities:

- Alberta Hospital Edmonton
- Alberta Hospital Ponoka
- Calgary General Hospital
- Charles Camsell Provincial General Hospital
- Foothills General Hospital: Calgary
- Grey Nuns Hospital
- Holy Cross Hospital: Calgary
- Lethbridge Regional Hospital
- Medicine Hat Regional Hospital
- Misericordia Hospital
- Northern Lights Regional Health Centre
  (formerly Ft. McMurray Regional Hospital)
- Queen Elizabeth II General Hospital: Grande Prairie
- Royal Alexandra Hospital
- University of Alberta Hospitals

Community Agencies And Organizations:

- Alberta Mental Health Consumer Network
- Alberta Vocational College
- Augustana University College: Camrose
- Brighton Block
- Calgary Police Department
- Canadian Abilities Foundation: Toronto, Ontario
- Canadian College of Health Service Executives: Ottawa, Ontario
- Canadian Institute for the Administration of Justice: Montreal, Quebec
- Canadian Institute of Law and Medicine: Toronto, Ontario
- Canadian Mental Health Association
  - Inuvik, North West Territories
  - Margaret House: Calgary
  - Provincial Office
  - Regional Offices
- Catholic Social Services
- Child and Adolescent Services Association
- Citizen's Commission on Human Rights
- College of Physicians and Surgeons of Alberta
- College of Psychologists of British Columbia
- College of Psychologists of Ontario
- Cook, Duke, Cox
- DLA International
- Duncan and Craig

- Edmonton Autism Society
- Edmonton Food Bank
- Edmonton Regional Day Centre Society
- Edmonton Social Planning Council
- Excel Resources Society
- Field and Field Perraton
- Gateway Association for Community Living
- Golden Circle Seniors Centre: Red Deer
- Grant MacEwan Community College
- Highlands Apartments
- House Next Door Society
- Jasper Place Composite High School
- JLR Human Care
- John Howard Society
- Landlord and Tenant Advisory Board
- Law Society of Alberta
- Legal Aid Society of Alberta
  - Provincial Office
  - Regional Offices
- McMan Youth Services Association
- Mustard Seed Church
- Provincial Health Council
- Provincial Mental Health Board
  - Provincial Office
  - Regional Offices
  - Regional Clinics
- RCMP
  - Airdrie Detachment
- Red Deer College: Red Deer
  - Department of Social Work
- Regional Health Authorities
- Salvation Army
  - Administration Office
  - Crisis Line
- Schizophrenia Society of Alberta
  - Advocacy Office
  - Calgary Office
  - Unsung Heroes
- Society for the Retired and Semi-Retired
- Support Network
- UNISOURCE Canada

- University of Alberta
  - Faculty of Law
  - Faculty of Nursing
  - Student Legal Services
- University of Calgary
  - Faculty of Nursing
  - Faculty of Social Work
- University of Montreal: Montreal, Quebec
  - Faculty of Law
- University of New Brunswick: Moncton, New Brunswick
  - Faculty of Law

Media Contacts:

- CBC Television: Toronto, Ontario
- Edmonton Journal
- QR77 Radio: Calgary
- Southam Information and Technology Group: Toronto, Ontario

General:

The issues brought to the Advocate's attention during 1995 covered a similarly wide range of topics to that observed in previous years. Items involving hospital privileges, clinical practices and administrative policies/procedures remain frequently cited problem areas but by far the most common concerns have continued to centre around involuntary detention and treatment for formal patients. Rights related issues focusing on apprehension and certification procedures under the **Mental Health Act** remain paramount, as do the **s.30** control provisions which permit the compulsory administration of medications in the absence of patient or surrogate consent. Other common areas of concern reflect records access problems, social/financial difficulties, appeal mechanisms (Review Panel/ Court of Queen's Bench) and competency/consent to treatment matters. As mentioned earlier, increasing numbers of calls appear to focus on problems involved in funding specialized treatment programs and locating appropriate accommodations or services in the community. Requests for assistance with disability pension problems, tax returns, AISH applications and ongoing financial obligations while detained in hospital also comprise increasingly common themes.

A few specific topics less frequently addressed during the year include:

- Allegations of sexual harassment;
- Care of pets while detained in hospital;
- Children's rights under the **Mental Health Act**;
- Costs of treatment for visiting non-Canadian citizens;
- Detention of informal (voluntary) patients;
- Discrimination of mental patients in social institutions and commercial malls;
- Employment difficulties for mentally ill citizens;
- Landlord complaints re tenants with psychiatric problems;
- Provision of legal documents to designated third parties;
- Restrictive smoking policies and privileges;
- Retrieval of lost or stolen belongings in hospital;
- Surrogate consent for ECT procedures;
- Treatment alternatives to criminal charges;
- Unwanted media coverage of apprehension under the **Mental Health Act**;
- Use of apprehension provisions in custody disputes and child welfare matters.

Out-of-Province Transfers:

Occasionally, presenting problems demand more detailed inquiries which can include the soliciting of formal legal opinions. One such issue involved compulsory out-of-province transfers for patients certified under the **Mental Health Act.** S.25 of the **Act** provides for such transfers in instances where "it would be in the best interests of a formal patient to be cared for in another jurisdiction." In cases where patients consent to inter-provincial relocation there would appear to be no problem. When patients do object to being compulsorily transported to another province, however, these provisions are at variance with their mobility rights under **s.6** of the **Canadian Charter of Rights and Freedoms** — particularly if the patient is an established Alberta resident. It seems strange that an ostensibly 'protective' provincial statute would prescribe so intrusive a measure, reflecting a degree of authority over an individual citizen which can not be executed even by that person's court appointed guardian.

In one case, a formal patient's attending psychiatrist believed it to be in the patient's best interests to be treated in another province at a facility near her family, but the patient vehemently objected to this compulsory cross-country relocation. While the hospital had delegated authority via a Ministerial Order to arrange for the inter-provincial transfer, questions pertaining to the patient's rights in this matter remained unclear since the **Mental Health Act** is silent on the matter of patient consent. A legal opinion was sought on whether inter-provincial transfers of formal patients against their wishes is permissible under current legislation, and if so, whether **s.25** of the **Mental Health Act** could be deemed unconstitutional in light of the aforementioned **s.6** provisions of the **Charter**. The respective legal opinions obtained from the Civil and Constitutional Law Divisions of Alberta Justice upheld the hospital's authority to implement involuntary inter-provincial transfers under **s.25** of the **Mental Health Act**, but were equivocal on whether this provision violates formal patients' mobility rights under the **Charter.**

Fortunately, this particular case resolved itself when the patient began to have second thoughts about the desirability of her transfer and stated that she did not wish the Patient Advocate's continued involvement in the matter. Ultimately, this inter-provincial transfer did occur, with the patient remaining ambivalent about her relocation throughout the planning process. This case was considerably more complex than indicated by this summary, with complicating factors deriving from the patient's pregnancy, her continual vacillation concerning the transfer, and elements involved in defining her 'best interests' vis-a-vis the proposed treatment plan and future family involvement in her affairs. Another complicating and unclarified issue deriving from this case is the authority of Mental Health Review Panels to adjudicate such matters in instances of dispute.

Patient Discharge and Continued Certification:

It came to the Advocate's attention that patients were being routinely discharged from a designated mental health facility while being treated as if their involuntary status remained in force. The legality of this practice was questioned, since it would seem necessary that patients remain on the hospital rosters as inpatients in order for their certificates to remain valid. It was clarified that the patients in question had indeed been fully discharged from the facility; suggestions that patients may simply be on leave under **s.20** of the **Act** were explicitly and repeatedly denied. Hospital personnel explained that it was common practice "for accounting purposes" to discharge patients and "take them off the books" while maintaining their certified status for control purposes on the part of the facility. Our initial contacts with the hospital failed to resolve the issue; officials insisted that the matter was "simply a semantic problem" since patients continued to receive outpatient services from the facility or an associated agency.

In one instance, a patient in the community was being compulsorily returned to hospital for regular ECT (electro-convulsive therapy) treatments to which he strenuously objected, even though he had been fully discharged from the facility for over a month. Despite the patient's community placement he remained certified under Renewal Certificates pursuant to the **Mental Health Act**; his involuntary and intrusive treatments were being administered via a Certificate of Incompetency (Form 11) under **s.27** of the **Act**. When the patient continued to decompensate in the community his Renewal Certificates were used to involuntarily re-admit him to the hospital, at which time he appealed to the Review Panel by way of contesting his compulsory treatment and continued involuntary detention. When the Review Panel convened some time later, it denied the patient's appeals by upholding both his detention and incompetency certificates.

The Patient Advocate Office argued, initially unsuccessfully, that if the patient's Renewal Certificates had been voided by his previous discharge from the facility, both his compulsory re-admission under these same certificates and his Certificate of Incompetency would also be invalid. Moreover, the authority of the Mental Health Review Panel to hear the patient's appeal would have been rendered forfeit, and the hospital could be vulnerable to potential legal damages for unlawful apprehension, confinement and possible battery. The Advocate decided to obtain independent legal opinions on this situation before pressing these points further with the Review Panel Chairman or the facility's governing body. Informal opinions were solicited through the Legal and Contract Services Branch of Alberta Health and a formal written opinion was obtained from Alberta Justice. Both sources supported the Patient Advocate's view that patients must be seen to require continuing detention *within* a designated facility in order for their certification and any concomitant compulsory treatment to remain legally viable.

The written opinion clearly confirmed that the **Mental Health Act** "does not contemplate having formal patients away from the institution other than by leave of absence or if they are transferred to another facility."

Upon receipt of this legal advice, contact was again made with senior facility officials, who this time responded promptly by issuing directives to all hospital personnel ensuring that patients whose certificates were being maintained continued to have designated inpatient status. In addition, any patients currently on leave of absence from the facility were required to be registered as inpatients or have their certificates cancelled. Once again, the collective cases involved with this issue were substantially less straightforward than suggested by this cursory summary review.

Consent re Behavioural Programs:

Most matters, even complex systemic issues, do not require the obtaining of formal legal opinions. One such question was whether behavioural programs fall under the rubric of 'treatment' and are hence subject to the consent and appeal provisions of the **Mental Health Act**. While psychosurgery is explicitly defined, the **Act** is silent on any generic definition of treatment. Our office has operationally defined the term 'treatment' to include any clinical interventions formally prescribed on the doctor's order sheet — whether these be medications, psychotherapy, ECT or behavioural programs. The only exceptions would be hospital privilege restrictions prescribed for purposes of patient security.

In one instance, confusion arose as to whether group and individual behaviour modification programs are to be considered treatment — clinical as opposed to administrative forms of intervention. Discussions with medical staff and hospital officials enabled us to finally convince the facility that behavioural programs do indeed constitute therapeutic interventions, and hence should be subject to the **Act's** consent and appeal provisions in the same manner as ECT or the administration of medications. If patients are incompetent to give informed consent for behavioural interventions, 'Form 11' Physicians' Certificates allowing surrogate consent under **ss.27** and **28** would apply. Conversely, if patients are deemed competent but are uncooperative with treatment, the **s.29** Treatment Order provisions would be applicable, and both these provisions could in turn be subject to adjudication by the Mental Health Review Panel. The Patient Advocate Office's interceding in this matter assisted the facility in clarifying its policies and procedures with respect to behavioural programs, and ensured that patients' treatment rights are protected via statutorily prescribed consent provisions and appeal mechanisms.

Patient Abuse:

'Abuse' is a term widely used in complaints coming to the Advocate's office for inquiry or investigation. While allegations of patient abuse are always taken seriously, we find that the term is employed loosely to cover a broad spectrum of perceived injustices, ranging from patients failing to receive copies of their Admission Certificates to claims of verbal harassment or physical assault. Our office has adopted a fairly narrow operational definition of abuse; the term is used only in relation to inappropriate actions which could result in emotional or physical harm. A patient's compulsory detention under due process of law, or a reluctance of staff to issue day passes or off-unit privileges for patient security purposes do not constitute abuse despite patients' perceptions and protestations to the contrary. These matters are better described in a way which can clarify the complaint by more clearly capturing the specific nature of the presenting problem. This is not to imply that patients' allegations of abuse or their perceptions of being abused by the system are to be taken lightly; rather, it simply suggests that a more specific delineation of occurrences and their context often serves as an important first step in formulating and attaining the compromises required for complaint resolution.

Since contemporary audit, quality assurance, peer review and accreditation mechanisms routinely monitor most current hospital practices, potential opportunities for the undetected abuse of vulnerable persons within designated facilities would appear less abundant than may be the case for certain segments of the community service network which are subject to fewer controls and closely scrutinized standards of care. It is thus not surprising that incidents of actual abuse have proved relatively infrequent over the six years our office has been in operation. Even incidents involving evidence of physical injury are not necessarily indicative of abuse. If an agitated, volatile or violent patient is thrashing about and requires numerous nursing staff to subdue him/her in order to administer control medications, bruises or abrasions can sometimes be inevitable. Indeed, it is applications of the **s.30** provisions of the **Act** that most often give rise to patient allegations of abuse, and it is not uncommon for patients to sustain minor physical injuries as the result of incidents which have necessitated staff intervention involving these control provisions. If our investigation reveals that greater levels of force were applied than would seem to be required by the circumstances involved, we would tend to use the term 'undue force' rather than 'abuse' — reserving the latter term for instances where reasonably clear indices of ill intended, negligent or unprofessional conduct are in evidence.

Presenting problems of this nature pose difficulties for any investigator. One must rely at least in part on documented evidence in the clinical records for assessing both the veracity of verbal information and the credibility of principal

parties. A clearly cited need for control intervention, particularly if accompanied by a documented history of volatility or violence on the part of the patient, can influence investigative judgements as to whether undue force or abuse is likely to have occurred. The involvement of independent witnesses or law enforcement personnel can also contribute significantly to a clear resolution of patients' claims or accusations. Even in instances where charges and concomitant police involvement are not considered appropriate or necessary, abuse allegations invariably prescribe formal investigative protocols as opposed to the informal inquiries routinely employed to resolve most patient concerns.

Patients can also complain of being 'abused' by other co-patients, in which case investigative findings would again not necessarily focus on perceived abuse *per se*, but rather on inappropriate attention levels or lack of diligence on the part of staff in rendering their duty of care to both the injured and offending patients. In short, while complainants typically do not surrender the term 'abuse' easily or happily, more precise descriptive labelling of complaints often serves to clarify patients' perceptions of events which have occurred, thus facilitating resolution and the prevention of similar incidents in future.

Systemic Issues:

Numerous systemic issues documented in the Patient Advocate's 1993 Annual Report remain unresolved. These focused on inadequacies inherent in the **Mental Health Act** and presenting problems deriving from these statutory shortcomings. They included such serious items as the absence of a valid consent mechanism for formal patients who are deemed incompetent to make their own treatment decisions but for whom there is no nearest relative meeting the surrogate consent requirements of the **Act**. They also highlighted perceived deficiencies in the rights provisions for minors and persons under single Admission Certificates; some clarified as well operational concerns involving the scope of authority for the Patient Advocate Office. These collective concerns have remained largely unaddressed since the office's inception in 1990; the need for a review of the office's mandate in particular has been supported by many agencies and independent authorities — including the Office of the Provincial Ombudsman. The reader is referred to the Patient Advocate's previous Annual Reports for more detailed coverage of these and other related issues. Hopefully, remedies are in the making.

Index to Appendices

Rights Summary for Formal Patients

If you are a formal (involuntary) patient under the **Mental Health Act** you have numerous rights. The Mental Health Patient Advocate Office has summarized a few of these rights for your information.

Rights Regarding Your Detention

You have the right to be informed of the reasons for your involuntary detention, and to receive copies of your admission or renewal certificates.

You have the right to appeal being kept in hospital against your will by applying to the Review Panel.

> The hospital will provide you with the name and address of the Review Panel Chairman, an application for review (Form 12), and any assistance you may require in making your application to the Review Panel.

You and your lawyer **have the right** to be present when evidence is given at the Review Panel hearing, and to question any person who gives evidence.

You have the right to appeal a decision of Review Panel to not cancel your admission or renewal certificates.

Rights Regarding Your Treatment

You have the right to refuse a treatment if you are mentally competent to make your own treatment decisions.

> If you object to treatment, your doctor may apply to the Review Panel. The Review Panel will review your situation, and either support your objection or support your doctor's application for a compulsory treatment order.

You have the right to apply to the Review Panel for a hearing to appeal your doctor's certificate (Form 11) stating that you are not mentally competent to make your own treatment decisions.

You and your lawyer **have the right** to be present when evidence is given at Review Panel hearings, and to question any person who gives evidence.

You have the right to appeal a treatment order or other written decision of the Review Panel.

General Rights

You have the right to contact and receive visits from your lawyer at any time.

> You may arrange legal representation for your Review Panel hearing if you so desire. Appeals of Review Panel decisions are made to the court of Queen's Bench, and will require the assistance of a lawyer.

You have the right to confidentiality for all clinical records pertaining to your care in hospital, and for any communications written by you or to you. Hospital staff cannot open, read, withhold or interfere with the delivery of your correspondence.

You have the right to receive visitors during visiting hours fixed by the hospital unless your doctor thinks that visitors would be harmful to your health.

You have the right to contact the office of the Mental Health Patient Advocate regarding any questions or concerns that you might have with respect to your rights or care while in hospital.

For additional information call the Mental Health Patient Advocate Office at:

- Edmonton: **422-1812**
- Other Centres in Alberta:
  Call Local **RITE** Operator — ask for **422-1812**
  (No long distance charges apply)

Part 6 — Mental Health Patient Advocate

Definition

44 In this Part, "Patient Advocate" means the Mental Health Patient Advocate appointed under section 45.

Patient Advocate

45(1) The Lieutenant Governor in Council shall appoint a Mental Health Patient Advocate, who shall investigate complaints from or relating to formal patients and exercise such other powers and perform such other duties as are prescribed in the regulations.

(2) The Lieutenant Governor in Council may make regulations

(a) respecting the powers and duties of the Patient Advocate;

(b) requiring boards to make available any information referred to in the regulations for the purpose of an investigation by the Patient Advocate.

Employees and advisors

46(1) In accordance with the Public Service Act there may be appointed any employees required to assist the Patient Advocate in performing his duties under this Act.

(2) The Patient Advocate may engage the services of lawyers, psychiatrists or other persons having special knowledge in connection with his duties under this Act.

Annual report

47(1) As soon as possible after the end of each year, the Patient Advocate shall prepare and submit to the Minister a report summarizing his activities in that year.

(2) On receiving a report under subsection (1), the Minister shall lay a copy of the report before the Legislative Assembly if it is then sitting, and if not, within 15 days after the commencement of the next ensuing sitting.

Mental Health Act

Regulation: Designation of Facilities

The following thirteen hospitals are designated under the **Mental Health Act** as facilities for the care, observation, examination, assessment, treatment, detention and control of persons suffering from mental disorder:

- The Alberta Hospital Edmonton;
- The Alberta Hospital Ponoka;
- The Calgary General Hospital;
  - Bow Valley Centre;
  - Peter Lougheed Centre;
- The Caritas Health Group:
  - Grey Nuns Hospital, Edmonton;
  - Misericordia Hospital, Edmonton;
- The Foothills Provincial General Hospital, Calgary;
- The Holy Cross Hospital, Calgary;
- Lethbridge Regional Hospital;
- Medicine Hat Regional Hospital;
- Northern Lights Regional Health Centre (formerly Ft. McMurray Regional Hospital)
- Queen Elizabeth II Hospital, Grande Prairie;
- Royal Alexandra/Charles Camsell Hospitals, Edmonton;
- University of Alberta Hospitals, Edmonton.

The Forensic Services of The Calgary General Hospital and The Alberta Hospital Edmonton are designated as facilities for the purposes of **s.13** of the Act.

Mental Health Act

Patient Advocate Regulation

Table of Contents

Definitions

1 In this Regulation,
(a) "Act" means the Mental Health Act;
(b) "formal patient" includes a person who has been a formal patient;
(c) "Patient Advocate" means the Mental Health Patient Advocate appointed under the Act.

Delegation

2 The Patient Advocate may in writing delegate to any person holding any office under him any power or duty conferred or imposed on him under the Act or the regulations under the Act, except the power of delegation in this section and the power or duty to make any report under the Act or regulations.

Power to act on a complaint relating to a formal patient

3(1)On receipt of a complaint from or relating to a formal patient, the Patient Advocate
(a) shall notify the board of the facility in which the formal patient is detained of the nature of the complaint,
(b) shall notify the formal patient, in writing, that a complaint has been received, of the nature of the complaint and of any investigation arising from the complaint,

(c) if a person other than a formal patient is named in the complaint, shall notify that person of any investigation arising from the complaint, and
(d) shall make any contact with the formal patient and conduct any investigation of the complaint that the Patient Advocate considers necessary.

(2) If a complaint relates to a formal patient who has been transferred from one facility to another, the notice under subsection (1) (a) shall be provided to the boards of both facilities.

(3) A formal patient and a person who has received notice of an investigation under subsection (1) (c) has the right to make representations to the Patient Advocate relating to the complaint.

(4) The Patient Advocate may investigate a complaint only as it relates to the period during which the person who is the subject of the complaint was subject to 2 admission certificates or 2 renewal certificates.

(5) On receipt of a complaint, the Patient Advocate shall provide to the formal patient and to the complainant, as far as is reasonable, information respecting the following:
(a) the rights of the formal patient under the Mental Health Act;
(b) how the formal patient may obtain legal counsel;
(c) how to make an application to the review panel;
(d) how to commence an appeal to the Court of Queen's Bench.

Power to initiate an investigation without a complaint

4 The Patient Advocate may, without receiving a complaint, initiate and conduct an investigation into
(a) any procedure of a facility relating to the admission of a person detained in the facility pursuant to the Act, and
(b) any procedure of a facility
(i) for informing a formal patient of his rights, or
(ii) for providing information as required by the Act to guardians, nearest relatives or designates of a formal patient.

Procedures

5(1) The Patient Advocate

(a) shall maintain a record relating to every complaint and every investigation under this Regulation, and

(b) may make any inquiries he considers necessary to conduct an investigation.

(2) The Patient Advocate shall notify the board of a facility of his intention to contact a patient or a formal patient of the facility and the board shall grant the Patient Advocate access at all reasonable times.

(3) The Patient Advocate shall notify the board of a facility of his intention to carry out an investigation that relates to the facility, whether the investigation arises pursuant to section 3 or 4.

(4) The Patient Advocate is not required to hold a hearing.

(5) If the Patient Advocate requests in writing from the board of a facility

(a) any policy or directive of the facility,

(b) any medical or other record or any information, file or other document relating to a patient or a formal patient who is the subject of an investigation under section 3 or 4, or

(c) any other information, file or document relating to an investigation under section 3 or 4,

the board shall, within a reasonable time after receipt of the request, provide access to the materials requested.

(6) If the Patient Advocate so requests, the board shall provide a copy of any materials requested under subsection (5).

Disclosure

6 The Patient Advocate shall not disclose information obtained in the course of an investigation except as required by law or in the performance of his duties under the Act or this Regulation.

Report

7(1) On completion of an investigation, the Patient Advocate shall prepare and send to a board a copy of the report of the investigation.

(2) A report that contains recommendations shall state the reasons for the recommendations.

(3) If a report is sent to a board under subsection (1) and within a reasonable time after the report is sent to the board the Patient Advocate is of the opinion that the board has not taken appropriate action on any recommendation, the Patient Advocate shall send a copy of the report and the board's response, if any, to the Minister.

Frivolous complaint

8 The Patient Advocate may refuse to investigate or cease to investigate a complaint if in his opinion

(a) the subject matter of the complaint is trivial,

(b) the complaint is frivolous or vexatious, or

(c) having regard to all of the circumstances, no investigation is necessary.

Notice to complainant

9 The Patient Advocate

(a) shall inform a formal patient of the disposition of any complaint that relates to the formal patient, and

(b) may inform a complainant of the disposition of any complaint initiated by the complainant.

Coming into force

10 *This Regulation comes into force on January 1, 1990.*